DAKOTACARE ADMINISTRATIVE SERVICES, INC.

HSA Employer Group Enrollment Application

To be completed by the employer and/or licensed agent when requesting Health Savings Account services.

Please select one: ☐ New or ☐ Renewal

EMPLOYER INFORMATION

Employer name _____ Employer tax ID number _____

Employer main office address 1 _____

City _____ State _____ ZIP _____

Employer main office address 1 _____

City _____ State_____ ZIP _____

AGENT INFORMATION

Agency name _____ Contact name _____

Agent business address _____ City _____ State _____ ZIP _____

Phone _____ Email _____

Fax _____ Tax ID number _____ ID license _____

POLICY INFORMATION

Effective date of High Deductible Health Plan _____

ENROLLMENT INFORMATION

Method of enrollment (must select one of the following as the primary enrollment): Online ☐ Paper ☐ Other ☐

Open enrollment period from _____ to _____.

CONTRIBUTIONS

Will payroll deductions be transferred into the employee's account? Yes ☐ No ☐

Will the employer be contributing to the employee's Health Savings Account? Yes ☐ No ☐

If yes, employer contribution schedules: ☐ Initial ☐ Weekly ☐ Semi-monthly ☐ Monthly

Enrollment mid-year pro-rate schedules: ☐ Initial ☐ Weekly ☐ Semi-monthly ☐ Monthly

CONTACT INFORMATION

Primary Employer Contact _____ Phone _____ Email _____

Secondary Employer Contact _____ Phone _____ Email _____

_____ Date _____ Print Name _____

Authorized Employer Signature, Title _____

Fax or mail completed form to:

DASFLEX 5300 S Broadband Lane Sioux Falls, SD 57108
Phone: 605-322-4774 Fax: 605-504-9305 Toll-Free: 1-888-322-2115
Email: dasflex@averahealthplans.com